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Letter dated 8 May 2014 from the Permanent Representative of Georgia to the United Nations addressed to the President of the Economic and Social Council

I have the honour to transmit the national report of Georgia on progress towards the achievement of the internationally agreed goals, including the Millennium Development Goals (see annex), for the annual ministerial review to be held during the high-level segment of the substantive session of 2014 of the Economic and Social Council.

I would be grateful for your kind assistance in circulating the present letter and its annex as a document of the Council, under item 5 (c) of the provisional agenda.

(*Signed*) Kaha **Imnadze**
Ambassador
Permanent Representative

* E/2014/1/Rev.1, annex II.

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Annex to the letter dated 8 May 2014 from the Permanent Representative of Georgia to the United Nations addressed to the President of the Economic and Social Council

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I. Review of the status of implementation of the Millennium Development Goals in Georgia

Basic country information

1. Georgia is a country covering around 70,000 km^2, lying on the southern foothills of the Greater Caucasus mountain range, and on the south-eastern shores of the Black Sea. It is bordered by the Russian Federation to the north, Turkey to the south-west, Armenia to the south and Azerbaijan to the south-east. Georgia has a population of 4.5 million (as of 2013, see also table 1), the country has long been ethnically heterogeneous and 54 per cent of the population lives in urban areas.

2. Georgia is a lower-middle-income country, according to the classification by the World Bank. Over the past 20 years the country has achieved significant economic growth with gross domestic product (GDP) per capita rising from $690 in 2000 to $3,597 in 2013. Poverty indicators decreased in parallel with economic progress, though unemployment remains relatively high, at 15 per cent as of 2012.

Table 1
Basic demographic data

	2013	
	Number	*Rate per thousand*
Live births	57 878	12.9
Natural population growth	9 325	2.1
Deaths	48 553	10.8
Migration dynamics	-2 606	-0.6

Source: National Statistics Office of Georgia (GeoStat).

Commitments to human development

3. Since its independence in 1991, Georgia has ratified core international instruments for human rights, including the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women, the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights, and the Universal Declaration of Human Rights.

4. In 2000, alongside the adoption by the General Assembly of the United Nations Millennium Declaration (General Assembly resolution 55/2), Georgia made a commitment to integrate the Millennium Development Goals within its national development strategies and plans and to periodically report on the status of implementation of the Goals.

5. In 2014, the country developed an integrated, multisectoral strategy for human rights that defines the overarching framework of action for the Government and main stakeholders as to how to enhance the protection and promotion of human rights, including the provisions envisaged by the Goals.

6. In 2013, the Government of Georgia launched its flagship programme on universal health care, which ensures that every citizen of Georgia has access to a

basic package of outpatient, inpatient and emergency health services. Stemming from General Assembly resolution 67/81, with its focus on universal health coverage, and the World Bank's global vision of universal health coverage by 2030, the programme has been another visible demonstration of Georgia's commitment to health-related Goals and the broader human development agenda. International partners, including the World Health Organization (WHO), the World Bank and the United States Agency for International Development (USAID) have been actively engaged in supporting the country in successful implementation of the national universal health care endeavour.

7. Section II of the present report provides an overview of the status of implementation of the Millennium Development Goals in Georgia, along with the relevant policies put in place as of April 2013.

II. Status of implementation of the Goals and related policies

Goal 1. Eradicate extreme poverty and hunger

Targets

1. Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day, measured through trends in relative and extreme poverty rates.

2. Achieve full and productive employment and decent work for all, including women and young people.

3. Halve, between 1990 and 2015, the proportion of people who suffer from hunger, measured through the prevalence of among children under the age of 5 who are underweight.

8. Georgia has enjoyed impressive economic growth since the early years of its transition to independence, owing largely to a wide range of reforms. GDP per capita has increased from $690 in 2000 to $3,597 in 2013. Positive trends in economic development were challenged by the war with Russia in August 2008 and the world economic crisis, although the negative trends started to reverse in 2010. Georgia's economy grew by 3.2 per cent in 2013.

9. Economic growth was paralleled by progress in poverty reduction. The level of extreme poverty (a level of income set at 40% of the median household income) decreased from 10.9 per cent in 2004 to 9.3 per cent in 2012, while relative poverty (a level of income set at 60% of the median household income) decreased from 24 per cent in 2004 to 22.4 per cent in 2012.

10. The introduction and continued expansion of social protection schemes provided a safety net for the most socially vulnerable population groups, including families living in poverty, old-age pensioners and people with disabilities. In 2013, old-age pensions and social allowances were increased from 2012 baselines by 50 per cent and 100 per cent, respectively. Overall, the social allowance for old-age pensioners increased 10.7 times, from GEL 14 in 2000 to GEL 14 in 2013.

11. Despite such progress, however, poverty rates were not significantly reduced and both the incidence and severity of poverty remain of great concern to the country. According to a 2012 welfare monitoring survey by the United Nations

Children's Fund (UNICEF), 77,000 children under the age of 16 live on less than $1.25 per day and more than 200,000 (one quarter of the total child population) consume less than 60 per cent of median consumption, which is approximately $2 per day. Data from a 2013 survey supported by UNICEF revealed a declining trend in extreme poverty among children, from 9.4 per cent in 2011 to 6 per cent in 2013. Children have indirectly benefited from doubled social allowances and increased old-age pensions, however 27 per cent of children continue to live below 60 per cent of the median household income.

12. Unemployment remains high at 15 per cent as of 2012, with estimated youth unemployment exceeding 30 per cent (see table 2). More than 70 per cent of the population regard themselves as unemployed, as reported by the National Democratic Institute, according to a public opinion survey from 2012. Furthermore, 70 per cent of the population remains economically or socially vulnerable according to a study by the United Nations Development Programme (UNDP) from 2012.

13. The Government of Georgia is developing new strategies and economic reforms to promote sustainable economic growth for the 2014-2020 cycle. The social and economic development programme focuses on encouraging private sector development and promoting professional education and local self-governance reforms.

Table 2
Employment trends, Georgia, 2000-2012

	2000	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*
Youth employment rate, ages 15-24, both sexes	21.2	20.1	27.9	24.6	28.3	28.3	29.3	31.5	35.5	38.7	36.3	35.6	–
Employment-to-population ratio, both sexes, percentage	60.11	58.8	56.8	58.4	56.6	55.2	53.8	54.9	52.3	52.9	53.8	55.4	56.8
Employment-to-population ratio, men, percentage	67.3	67.1	65.1	67.4	64.2	62.6	61.2	63.1	61.1	61.1	61.2	63.7	65.6
Employment-to-population ratio, women, percentage	54.0	52.0	49.9	50.9	50.2	48.8	47.7	48.1	44.9	45.9	47.5	48.5	49.5

Source: National Statistics Office of Georgia.

14. The prevalence of children under the age of 5 who are underweight remains low. According to the multiple indicator cluster survey (2005), 2.1 per cent of children under the age of 5 were moderately underweight and the share of extremely underweight children was 0.3 per cent (see table 3). Similar results were confirmed by the national nutrition survey of 2009. Even if the prevalence is low, the 2012 survey by UNICEF revealed a high prevalence of micronutrient deficiency among pregnant women and children that the Government started to address in 2014 through targeted micronutrient supplementation programmes and regulations.

Table 3
Prevalence of children under the age of 5 who are underweight, Georgia, 2009

	Severely underweight	*Moderately underweight*	*None (normal)*
Total	**14 (0.5%)**	**25 (0.6%)**	**2 981 (98.8%)**
Male	7 (0.4%)	19 (0.9%)	1 599 (98.7%)
Female	7 (0.6%)	6 (0.4%)	1 382 (99.0%)
By region			
Tbilisi	3 (0.8%)	1 (0.3%)	360 (98.8%)
Ajara and Guria	2 (0.6%)	1 (0.3%)	337 (99.1%)
Imereti and Racha-Lechkhumi	1 (0.5%)	2 (1.0%)	204 (98.6%)
Kakheti	2 (0.7%)	1 (0.3%)	304 (99.0%)
Kvemo Kartli	2 (0.3%)	8 (1.1%)	751 (98.7%)
Samegrelo	1 (0.4%)	3 (1.1%)	272 (98.6%)
Samtskhe-Javakheti	3 (0.6%)	8 (1.6%)	490 (97.8%)
Shida Kartli and Mtskheta-Mtianeti	0	1 (0.4%)	263 (99.6%)

Source: National nutrition survey, 2009.

Goal 2. Achieve universal primary education

Target

Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.

15. Georgia has a strong tradition of education, with almost universal primary school enrolment rates across the country. The country has maintained high levels of primary school enrolment (96%-100%) since 2000, with a gender parity index of 1.03 as of 2011.

16. In 2005, the Ministry of Education and Science introduced inclusive education and the concept of inclusive schools. As of the time of reporting, all schools in Georgia are providing inclusive education with special attention given to an individual approach and an individual, student-centred curriculum. The inclusive education concept has raised accessibility at all stages of the general education system. The system is in the process of improving the quality of inclusive education in Georgia.

17. However, the quality of the education system has been a concern. According to the Trends in International Mathematics and Science Study (2011), Georgian eighth grade students ranked 26 out of 28 participating European countries in mathematics and science. Furthermore, according to the Ministry of Education and Science, 2,388 students dropped out during the school year 2009-2010 and there is a need for more and better data on out-of-school children and children at risk of dropping out.

18. The ongoing education reform process is primarily focused on improving the quality of education and ensuring accessible and affordable education at different levels. Georgia joined the Bologna Process at the summit held in Bergen, in 2005, and the Ministry of Education and Science of Georgia initiated regulatory

amendments to facilitate the introduction of the Bologna principles in the higher education system.

19. Georgia is actively working on comprehensive reform of vocational education and training. Entities of the United Nations system, including UNDP and the International Labour Organization (ILO), as well as the European Union, have been assisting the country in the design and implementation of the systemic reforms for 2013-2020 to close the existing imbalance between education system supply and labour market demand.

Goal 3. Promote gender equality and the empowerment of women

Target

Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015.

20. Even during the critical socioeconomic transition of the early 1990s, the country substantially advanced its gender equality agenda, with progressive implementation of commitments laid out by the Convention on the Elimination of All Forms of Discrimination against Women.

21. As noted above, gender equality in education has not been a developmental challenge in the country. Georgia has maintained close to universal primary school enrolment both for girls and boys, with the latest data on gender parity index in primary, secondary and tertiary education standing at 1.03, 0.95 and 1.2, respectively. Education resource centres countrywide report 1.4 female-to-male ratio among public school principals, and 4 out of 5 school teachers in Georgia are women.

22. The country has made important progress in securing the education rights of children in socially disadvantaged families. However, female students from ethnic minority groups remain at a higher risk of dropping out. A recent study by the Millennium Challenge Corporation also revealed barriers to the equal participation of girls in science, technology, engineering and mathematics (STEM) education programmes. In this respect the Government plans to intensify work on the protection and promotion of women's rights in education and science. The Ministry of Education and Science is working with the United States Civilian Research and Development Foundation (CRDF Global) and local scientific foundations to promote talented female doctoral students and facilitate women's participation in scientific research.

23. In March 2010 Georgia adopted a law on gender equality and established a Parliamentary Council on Gender Equality. Since 2010, the Council has completed two biennial cycles of a strategic planning exercise for gender mainstreaming. Within the framework of the 2010-2013 National Action Plan, the Ministry of Education, in partnership with civil society, provided gender equality training to school teachers countrywide. The 2014-2016 National Action Plan envisages public awareness-raising on gender equality, mainstreaming gender aspects in education laws and promoting gender equality in education programmes relating to science, technology, engineering and mathematics and vocational institutions.

24. In 2012 Georgia surpassed the threshold level of 10 per cent as regards the representation of women in Parliament, from a 5 per cent baseline in 2000. Women

hold key ministerial portfolios in justice, education, foreign affairs and environmental protection and lead the National Security Council and the Central Election Committee. The economic empowerment of women has been also visible since the 1990s, with 30 per cent of women being primary breadwinners and 20 per cent heading business enterprises.

25. Despite the progress, women are still underrepresented at decision-making levels and their economic empowerment has to be further improved. According to the Gender Inequality Index, Georgia is placed 71 of the 137 countries surveyed. In 2012, the average nominal monthly salary of women in all fields of the economy and across industry sectors was 60 per cent of that of men.

26. A breakthrough in gender equality will only be possible as a result of the strong and coherent efforts of all stakeholders, including the Government, civil society and development partners.

Goal 4. Reduce child mortality

Target

Reduce by two thirds, between 1990 and 2015, the mortality rate of children under the age of 5.

27. According to official statistics from the National Statistics Office of Georgia, Georgia has substantially reduced the mortality rate of children under the age of 5, from 24.9 in 2000 to 13.0 in 2013, per 1,000 live births. A similar declining trend has been reported by the administrative health statistics unit of the National Centre for Disease Control and Public Health, with the mortality rate of children under the age of 5 decreasing from 27.2 in 2000 to 12.4 in 2012, per 1,000 live births.

28. Even if the discrepancy in data is high between the routine statistics and the reproductive health survey, significant progress concerning the reduction in the mortality rate among children under the age of 5 is evident and all data sources confirm the declining trend in child mortality (see table 4).

Table 4
Mortality rate of children under the age of 5; comparative data from official statistics, health statistics and household surveys (per 1,000 live births)

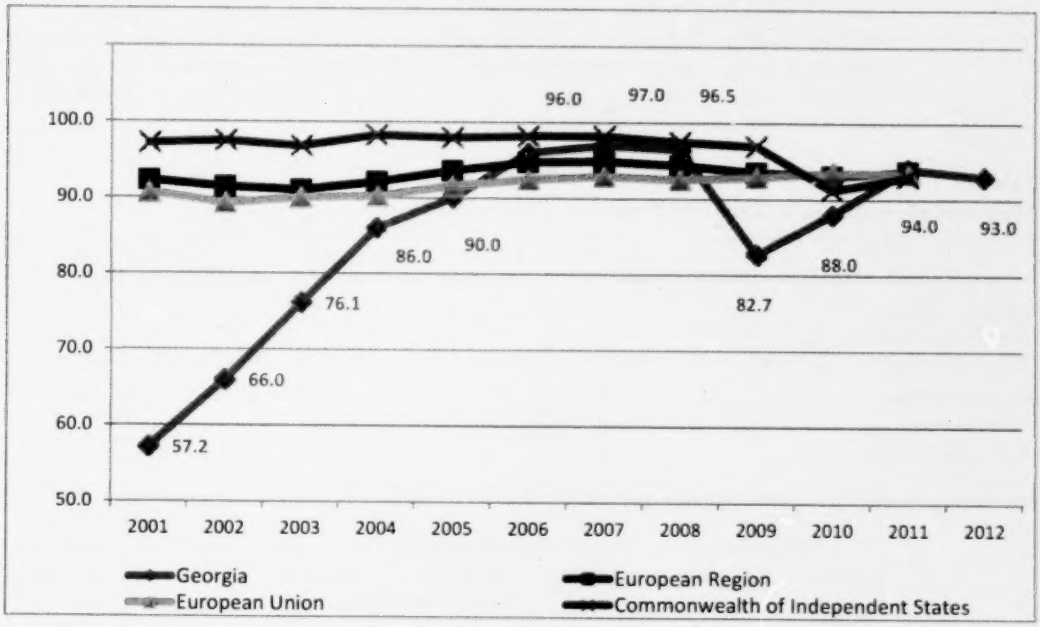
	2000	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*	*2013*
Health statistics	27.2	26.7	22.1	20.3	20.1	19.4	19.7	15.6	16.0	15.4	13.4	12.0	12.4	–
Official statistics (National Statistics Office of Georgia)	24.9	25.5	26.0	27.6	26.4	21.1	16.9	14.4	18.0	16.0	13.0	13.8	14.4	13.0
Reproductive health survey	45.8	–	–	–	–	25.1	–	–	–	–	16.4	–	–	–

29. After the disruption of routine vaccination services in the early 1990s, Georgia successfully restored and expanded the coverage of the national immunization programme. Since 2000 the country has maintained over 90 per cent coverage for the first measles-containing vaccine, reporting 93 per cent coverage by the end of 2012 (see figure I) and has further improved coverage to 96.5 per cent in 2013. The data is close to the European Union and the European region averages, although

further investment is needed for sustaining over 95 per cent coverage for the first dose of the vaccine and high coverage for the second dose of the vaccine. The latter is particularly important considering the measles and rubella elimination goal set by the States members of the World Health Organization European region for 2015.

Figure I

Percentage of 12 month-old children vaccinated against measles, 2001-2012



Source: National Centre for Disease Control and Public Health of Georgia and World Health Organization European Health for All Database.

30. Despite the documented progress, the rate of child mortality in Georgia is still the second highest in Europe. Child mortality is mainly attributed to infant mortality (87.5%), a situation which has not changed much since 2000 when the infant mortality rate fraction of the mortality rate for children under the age of 5 was 90 per cent. Furthermore, the 2010 reproductive health survey indicated significant differences in child mortality rates between urban and rural areas. The 2013 equity analyses by UNICEF of the excessive infant death rate in Georgia suggests that (a) infants outside Tbilisi were 1.4 times more likely to die than infants in Tbilisi, and (b) infants born outside Tbilisi weighing 1,500 grams or more were 1.9 times more likely to die than infants in Tbilisi before being discharged from maternity wards and 1.5 times more likely during the period after having been discharged.

Goal 5. Improve maternal health

Targets

1. Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.

2. Achieve, by 2015, universal access to reproductive health.

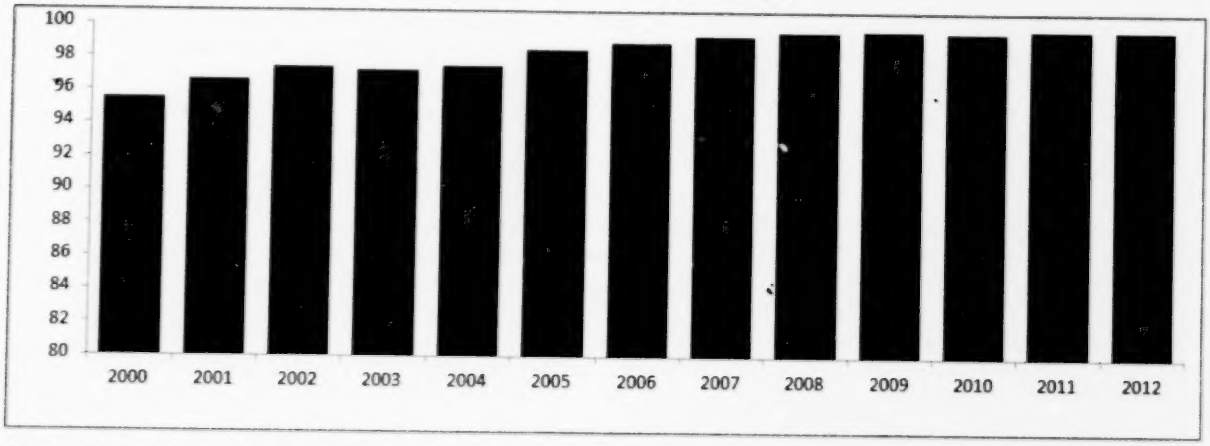
31. Georgia has reduced the maternal mortality rate by more than half, from 49.2 in 2000 to 22.9 in 2012, per 100,000 live births (see table 5). The 54 per cent reduction in the maternal mortality rate has been significant, however attainment of the three quarter reduction target for 2015, set out in the Millennium Declaration, will most probably be missed.

Table 5
Maternal mortality rate, 2000-2012 (per 100,000 live births)

	2000	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*
Official statistics (National Statistics Office of Georgia)	49.2	58.7	42.2	49.9	43.1	23.4	23.0	20.2	14.3	52.1	19.4	27.6	22.9
Reproductive age mortality study	–	–	–	–	–	–	44.0	–	–	–	–	–	–
Maternal mortality survey, 2011	–	–	–	–	–	–	–	–	–	–	20.6	–	–

32. The proportion of births attended by skilled medical personnel, which was already high at the time of adoption of the Millennium Declaration, was further increased, from 97.4 per cent in 2002 to 99.8 per cent in 2012 (see figure II and table 6).

Figure II
Proportion of births attended by skilled medical personnel (percentage)



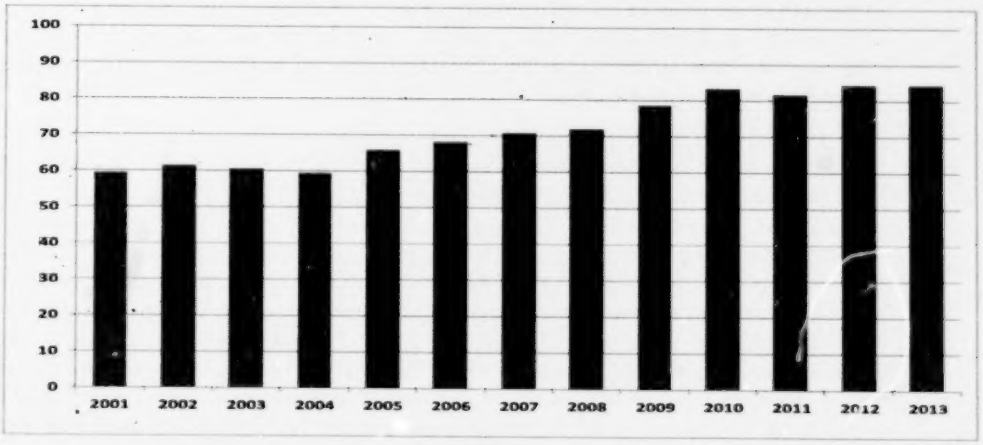
Source: National Centre for Disease Control and Public Health.

Table 6
Proportion of births attended by skilled medical personnel (percentage)

	1995-1999	*2000-2004*	*2005-2009*	*2012*
Health statistics	95.8	96.9	99.2	99.8
Reproductive health survey	92.2	92.5	98.8	–
Multiple indicator cluster survey	–	–	93.8	–

33. The number of pregnant women receiving the recommended four antenatal care visits has also been on the rise and totalled 84.2 per cent in 2013, compared with a baseline below 60 per cent baseline in 2001 (see figure III). The multiple indicator cluster survey, 2005, reported 97.4 per cent of pregnant women having visited antenatal care institutions at least once. The high rate of uptake concerning the recommended four antenatal care visits was confirmed by the reproductive health survey (98.8% in 2005-2009). Improved access to reproductive health-care services since 1999 has benefited women, especially those living in rural areas and those from groups with less access to education. The percentage of pregnant women with no access to antenatal care in the two groups fell, from 14 per cent and 30 per cent to 3 per cent and 6 per cent, respectively.

Figure III
Percentage of women receiving at least four antenatal care visits



Source: National Centre for Disease Control and Public Health.

34. Data on reproductive health-care services (apart from maternal and child health statistics) are mainly derived from household surveys. According to three reproductive health surveys conducted in the period from 2000 to 2010, total induced abortion rates have decreased from 3.7 to 1.6 (per woman), with a parallel increase in the prevalence rate of contraceptives (all methods) from 25 per cent to 32 per cent among all women of reproductive age (including from 41% to 54% among married women). The increase in contraceptive prevalence was attributed mainly to the increase in the use of modern contraceptive methods (from 20% in 2000 to 35% in 2010 among married women). The data from those surveys also

documented the reduction in the unmet need for family planning — for modern methods of family planning, the unmet need decreased from 27 per cent to 18 per cent (see table 7). This decrease could be attributed to partnership initiatives supported by USAID and the United Nations Population Fund (UNFPA) for ensuring access, free of charge, to modern family planning methods as well as the availability of socially marketed family planning products, the expansion of private sector partnerships and nationwide training of reproductive health-care service providers.

Table 7
Unmet needs for modern methods of family planning (percentage)

	2000	*2005*	*2010*
Women aged 15-44	27	22	18

Source: Reproductive health survey.

35. In order to further contribute to increased access to quality reproductive health-care services and address one of the main causes of mortality and morbidity of women of reproductive age, the Government, in partnership with UNFPA, has launched breast cancer and cervical cancer screening programmes, which provide services to women of the target age group, free of charge, in all regions of Georgia. At present, joint efforts are under way to plan and pilot the cervical cancer screening programme in order to ensure an increased participation rate and improved quality of the screening programme. Additionally, over 1,400 primary health-care providers were trained in breast cancer and cervical cancer prevention and early detection, with support from UNFPA and the USAID project for sustaining family planning and maternal and child Health services (SUSTAIN).

36. Despite the visible progress, 16 mothers died in 2013 owing to pregnancy-related causes, according to data reconciled from the National Statistics Office of Georgia and the National Centre for Disease Control and Public Health. The Ministry of Labour, Health and Social Affairs has intensified work for the enhancement of reproductive health statistics in partnership with United Nations entities (UNICEF and UNFPA), USAID and other international partners, with a particular focus on timely reporting and ascertainment of pregnancy-related deaths. With the technical assistance of the USAID SUSTAIN project, JSI Research and Training Institute, in collaboration with the National Centre for Disease Control and Public Health is conducting the 2014 reproductive age mortality study, with the aim of studying the mortality of women of reproductive age and of investigating the extent and causes of maternal mortality in Georgia.

Goal 6. Combat HIV/AIDS, malaria and other diseases

Targets

1. Halt and begin to reverse, by 2015, the spread of HIV/AIDS.

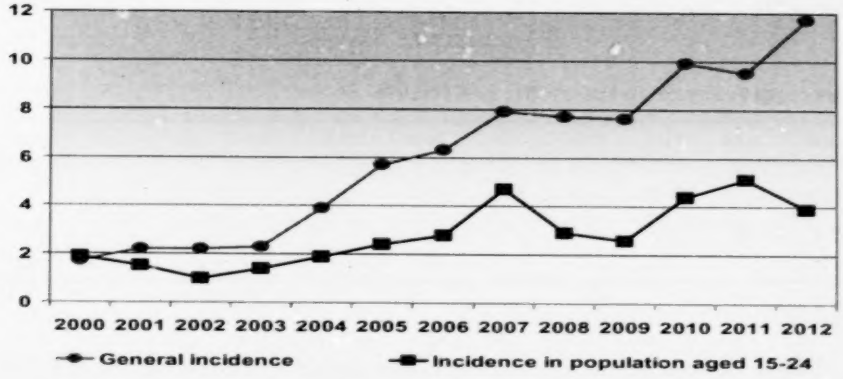
2. Achieve universal access to treatment for HIV/AIDS for all those who need it.

3. Halt and begin to reverse, by 2015, the incidence of malaria and other major diseases.

37. Georgia was one of the first countries in Central and Eastern Europe and the Commonwealth of Independent States region to attain universal access to antiretroviral treatment in 2004 and that status has been maintained over the past 10 years. This has translated into substantial improvement in the rate of survival and in quality of life for people living with HIV in the country.

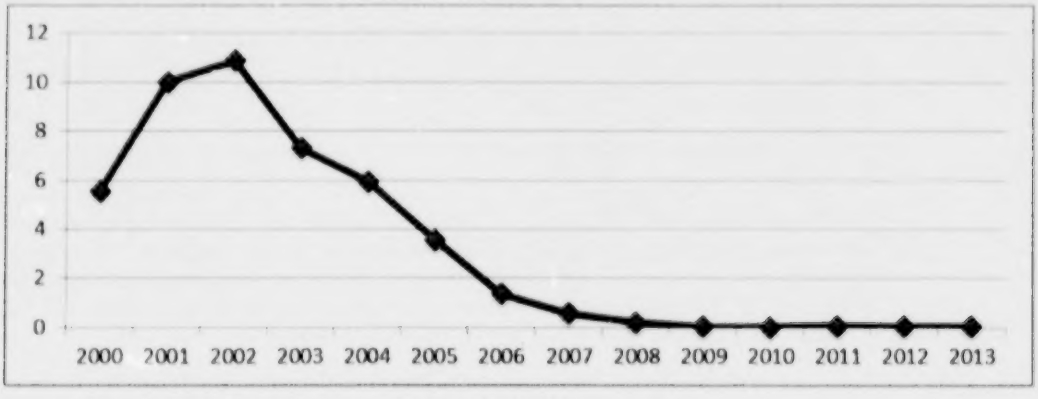
38. However the country still faces challenges in this regard, with a concentrated epidemic among high-risk behaviour groups, with a rise in HIV prevalence among men who have sex with men (from 3% to 13%) and over 5 per cent prevalence among people who inject drugs in some of the cities in western Georgia. The number of new HIV infections among young people aged between 15 and 24 also increased, from 2009 to 2011. In 2012, this indicator decreased by 23.5 per cent (see figure IV).

Figure IV
Incidence of HIV per 100,000 population



39. The country has made significant progress towards the elimination of malaria. Georgia documented a reduction in the incidence of malaria, from 5.5 per 100,000 people in 2002 to 0.02 per 100,000 in 2013 (see figure V) and reported no autochthonous malaria case in 2013. As a signatory of the Tashkent Declaration entitled "The Move from Malaria Control to Elimination", in 2005, Georgia is in the phase of preventing the reintroduction of malaria. In 2011 the country requested WHO certification as malaria-free.

Figure V
Incidence of malaria per 100,000 population



Source: National Centre for Disease Control and Public Health.

40. Georgia has also made significant progress in confronting the tuberculosis epidemic. The country has attained universal access to tuberculosis diagnosis and treatment since 2003, including multi-drug-resistant tuberculosis control interventions since 2008. According to WHO estimations, the overall incidence of tuberculosis and related mortality and prevalence rates in Georgia have been falling since 2000. New cases of tuberculosis per 100,000 population decreased from 96.5 in 2000 to 84.1 in 2012 and the prevalence in the same period fell from 133.4 to 110.7 (see table 8).

Table 8
Tuberculosis incidence, prevalence and mortality per 100,000

	2000	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*
Incidence	96.5	86.4	96.5	92.8	94.8	98.1	96.9	95.0	94.7	101.4	98.6	101.4	84.1
Prevalence	133.4	128.8	145.2	143.4	149.7	153.2	143.1	147.0	133.0	135.9	130.4	123.4	110.7
Mortality	–	–	3.1	3.5	4.3	5.3	5.4	5.9	5.2	4.6	4.1	3.5	3.9

Source: National Centre for Disease Control and Public Health.

41. Despite such progress, the country is challenged by a high burden of multi-drug-resistant tuberculosis, which greatly complicates Georgia's tuberculosis epidemic, since this type of the disease requires nearly two years of treatment with more toxic, more expensive and less effective medicines. Georgia is among the 27 countries with the highest burden of multi-drug-resistant tuberculosis in the world.

42. Through support from WHO, Georgia conducted the first-line anti-tuberculosis drug resistance survey in 2004-2006. The survey revealed multi-drug-resistant tuberculosis in 6.8 per cent of smear-positive new cases and 27.4 per cent of retreated cases. In 2011, the multi-drug-resistant form of tuberculosis was found in 10.9 per cent of new cases and in 31.7 per cent of retreated cases. Tuberculosis remains a particularly severe problem within the penitentiary system.

Goal 7. Ensure environmental sustainability

Targets

1. Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources.

2. Reduce biodiversity loss, achieving by 2010 a significant reduction in the rate of loss.

3. Halve, by 2015, the proportion of the population without sustainable access to safe drinking water and basic sanitation.

43. The Government of Georgia adopted the strategy and action plan on biodiversity preservation in its resolution No. 27 of 19 February 2004. The strategy covers the preservation of biodiversity over a period of 10 years, while the action plan is designed for a 5-year term. The elaboration of forestry policy and strategy started in 2005.

44. According to the multiple indicator cluster survey (2005), 94.2 per cent of the population used an improved drinking water source, with 78.9 per cent of households having drinking water piped into their dwelling and 17.3 per cent of the population needed less than 30 minutes to bring water to their home. According to the reproductive health survey, the proportion of the population to whom piped water, which properly meets hygienic rules, is available has not essentially changed in the period from 2000 to 2009. For the urban population, compared to the rural population, the indicator is increased by 30 per cent (see table 9). According to the multiple indicator cluster survey (2005), the vast majority of the Georgian population (96.8%) lived in households with improved sanitation facilities and 56.3 per cent of children under the age of 2 had access to toilets that followed proper hygienic rules. Furthermore, the reproductive health survey revealed a 3.7 per cent increase in the availability of flush toilets in households between 1995 and 2009.

Table 9
Availability of piped water (percentage)

	2000-2004	*2005-2009*
Reproductive health survey		
Urban	96.1	96.8
Rural	66.2	65.8
Multiple indicator cluster survey		
Total		94.2

45. Despite its rich water deposits, Georgia is still experiencing difficulties in supplying the population with safe drinking water in rural areas. Underground water deposits remain the main source of drinking water, providing 90 per cent of the water supply system. Currently 84 per cent of the urban population and 15.7 per cent of the rural population is centrally supplied with drinking water.

46. In recent years Georgia increasingly experienced the effects of climate change. The third national communication to the United Nations Framework Convention on

Climate Change will include the updated greenhouse gas inventory and will discuss the ways of minimizing emissions in the main cities of Georgia. It will also assist the Government in better analysing climate change risks and developing realistic scenarios for reducing their negative impact.

47. Georgia is developing strategies and action plans for increasing the national potential to effectively implement the requirements of global conventions on climate change, including biodiversity conservation, the fight against desertification, the elaboration of a national plan on implementation of the Stockholm Convention on Persistent Organic Pollutants, and the Kura-Aras basin preservation and integrated management plan.

Goal 8. Promote global partnership

Targets

1. Develop further an open, rules-based, predictable, non-discriminatory trading and financial system.

2. In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries.

3. In cooperation with the private sector, make available benefits of new technologies, especially information and communications technologies.

48. Georgia has one of the most liberal and competitive trade regimes in the world. There are no non-tariff barriers (prohibitions, restrictions, tariff quotas, licensing) in Georgian legislation except those cases where health, security, safety and environmental issues are concerned. Since 2006, Georgia abolished import duties on almost 85 per cent of goods and reduced the number of import duties from 16 to only 3 (0%, 5% and 12%).

49. After joining the World Trade Organization (WTO) in June 2000, Georgia started to harmonize its customs regimes with the commitments negotiated with WTO. Georgia's joining WTO resulted in the abolishment of the Jackson-Vanik amendment, in respect of Georgia, by the United States of America and, furthermore, granted the country most-favoured-nation status. Later, the country was granted the Generalized System of Preferences beneficiary status by Canada, Japan, Norway, Switzerland and the United States.

50. The European Union expanded the Generalized System of Preferences beneficiary status of Georgia, granted in 1995, to GSP+, which entitles more than 7,200 types of products of Georgian origin to enter the European Union market with zero customs tariff. In 2013, after the lifting by the Russian Federation of the embargo on agricultural products, such export products as wine, mineral waters and citrus have reentered the Russian market.

51. Georgia has free trade agreements with countries in the Commonwealth of Independent States and with Turkey. In November 2013, the European Union-Georgia Association Agreement, including a Deep and Comprehensive Free Trade Agreement, was initialled. It is expected to be signed by June 2014.

52. In April 2011, Georgia became the 135th country to officially adhere to the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action.

53. With regard to the affordability of essential drugs, Georgia has been using the global procurement mechanisms for vaccines and biologicals as well as HIV and tuberculosis drugs through cooperation with UNICEF, the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria. The country is working on maintaining access to the affordable prices after graduation from support by GAVI and the Global Fund in 2016. Furthermore, in 2014, Georgia made significant progress in the affordability of hepatitis C treatment, with a 60 per cent reduction of the price of PEG-IFN treatment in the local market for 11,000 beneficiaries.

54. Publicly funded health-care programmes to tackle such concerns as diabetes, dialysis and immunization universally cover the relevant medications and biologicals for patients. Universal health care and State-run health insurance programmes also cover priority medications for specific groups of beneficiaries as well as medications necessary for emergency care, elective surgery and cancer treatment. Recognizing the high prevalence of hypertension in the country, the Ministry of Labour, Health and Social Affairs works on policy options developed with the USAID Health Care Improvement project to support improved financial access to chronic disease medications.

55. The country has also documented substantial progress in access to and uptake of modern information and communications technologies. Mobile cellular subscription stands at 107.81 per 100 inhabitants in 2012, from as low as 10.90 in 2002. As of 2012, 45.5 out of 100 inhabitants are Internet users, an increase from fewer than 1.59 in 100 using the Internet in 2002.

III. Progress and remaining challenges vis-à-vis health-related Goals

56. The country has attained a number of historic gains vis-à-vis health related Millennium Development Goals, including decreases in the maternal mortality rate from 49.2 in 2000 to 22.9 by 2012 (per 100,000 live births); a reduction of the infant mortality rate from 22.5 to 11.1 (per 1,000 live births) (according to GeoStat) and in the mortality rate of children under the age of 5, from 24.9 in 2000 to 13.0 as of 2013 (per 1,000 live births). Abortion rates have also decreased (from 3.7 in 2000 to 1.6 in 2010, per woman) with a parallel increase in the contraceptive prevalence rate (from 20% to 53% in married women). Finally, universal access to antiretroviral HIV treatment and tuberculosis treatment has been maintained since 2003 and Georgia is on the way towards certification of malaria elimination.

57. The present national report synthesizes some of the main policy interventions that have helped the country in advancing the progress on health-related Goals, remaining challenges, lessons learned and the vision for future interventions and partnership.

Goals 4 and 5. Maternal and child health

What has worked?

58. Progress in the reduction of maternal, neonatal and child mortality has been attained through a number of facilitating factors, including political commitment, resource investment (both domestic and international), investment in the quality of data and evidence-based policies across ante-, peri- and post-natal care services.

Political commitment

59. The improvement of maternal, newborn and child health outcomes has been positioned among the strategic health priorities throughout national development plans and health sector strategies since 1999. The latest national health system performance assessment and the 2014-2020 strategic framework on universal health care and quality management for the protection of patients' rights also positions maternal, newborn and child health among nine strategic priorities. Finally, maternal and child health promotion stands out among core priorities of the "Social-Economic Development Strategy, Georgia 2020". The Ministry also hosts the Maternal and Child Health Coordinating Council, which brings together all major stakeholders to ensure coherent analysis and action for improvement of maternal, newborn and child health policies and related health outcomes.

Resource investments

60. Maternal and child health-care services are integrated into the State programmes to improve ante-, peri- and postnatal care as well as paediatric services for children under the age of 18 countrywide.

61. The State programmes envisage four antenatal care visits, screening for hepatitis B and C, syphilis and HIV during pregnancy and interventions for the prevention of mother-to-child transmission of such infections. Since July 2013, every pregnant woman is guaranteed State funding for maternity services, covering both physiological and caesarean section deliveries.

62. Reaching every newborn with quality care around the time of childbirth and the days immediately after birth has a critical role to play. Targeted interventions for newborns include essential newborn care, which is effectively used (in 95% of cases) in maternity care practices countrywide. State programmes for newborns include screening for hypothyroidism, phenylketonuria, hyperphenylalaninemia, cystic fibrosis and hearing loss.

63. In addition, every child under the age of 18 is guaranteed a basic package of primary health-care services (including immunization), emergency inpatient and outpatient care, elective surgeries and cancer treatment.

64. In addition to domestic resource allocation, international support in promotion of effective perinatal care has been an important catalyst for change. Programmes supported by USAID and implemented through JSI Research and Training Institute and SUSTAIN projects have facilitated the scaling up of evidence-based perinatal care interventions nationwide and ensured the training of perinatal care personnel. Support from both USAID and UNICEF was critical in the assessment of perinatal care facilities countrywide in 2013 and in the elaboration of the perinatal care regionalization plan for maternity services and newborn care.

65. The restoration and expansion of routine child immunization has been another significant achievement over the past 20 years. The current national immunization schedule includes BCG; hepatitis B; diphtheria, pertussis and tetanus, hepatitis B and haemophilus influenzae type B (DPT-HepB-Hib); diphtheria (DPT); oral polio vaccine/inactivated polio vaccine (OPV/IPV); measles, mumps and rubella (MMR); and diphtheria and tetanus (DT) vaccines. Support from UNICEF and USAID was significant in funding the immunization programme from 1993 to 2006. Independent vaccine initiatives have been an important step for the country, as Georgia

successfully phased out from UNICEF support in the provision of traditional vaccine antigens and has maintained self-sufficiency in vaccine and injection supply procurement since 2006. Support from the GAVI Alliance and the Rostropovich-Vishnevskaya Foundation enabled the country to start measles, mumps and rubella vaccination in 2003. With technical support from WHO, GAVI Alliance is also supporting Georgia in the introduction of new vaccines, such as rotavirus from 2013 and pneumococcal vaccine from 2014.

66. UNFPA support has been critical in building national capacities for the provision of reproductive health and family planning services, including through human resource development at the primary care level and perinatal care facilities as well as the provision of modern family planning methods to the health sector during the past 15 years, free of charge. These efforts contributed to a substantial decrease in the total induced abortion rate (from 3.7 in 1999 to 1.6 in 2010, per woman) coupled with an increase in the prevalence of modern family planning methods, as documented in reproductive health surveys for the years 1999, 2005 and 2010.

Investing in data quality for decision-making

67. While decreasing trends regarding the rates of maternal and child mortality are encouraging, the discrepancy between administrative statistics and survey data remains a concern. The Government has mobilized resources to tackle the problems related to maternal and child health service fragmentation by preparing the background for the introduction of the new maternal and child health management information system. The system will be (a) capable of tracking mother and child throughout the entire cycle (pregnancy, delivery and perinatal care, childcare until child reaches the age of 6); (b) well-thought out to ensure access to the data currently lacking; (c) proficient enough to transform the raw data into useful information and serve as a powerful tool for quality management of maternal and child health, which supports evidence-based decisions and policymaking. UNICEF has supported the Government in this endeavour and as a result the instruments for data collection and data analysis have been developed.

68. In addition, on the basis of an assessment of the completeness and quality of a death registration survey, conducted with support from WHO, recommendations are provided for the harmonization of vital registration systems among the key players (the National Centre for Disease Control and Public Health; the Public Service Development Agency and the National Statistics Office of Georgia).

69. For better monitoring of maternal and child mortality cases, the Ministry launched an emergency notification system in February 2013. The system ensures immediate notification to the Ministry of every maternal death, death of a child under the age of 5, or cases of stillbirth. The information is accumulated in the database, analysed and presented to the Maternal and Child Health Board of the Ministry of Labour, Health and Social Affairs on a monthly basis. On the basis of the analysis, the Board discusses real-time data and recommendations for improvement of the perinatal system performance. For instance, a 2013 review revealed that in two thirds of maternal death cases, pregnant women had not accessed antenatal care at all, or had done so only partially. The Board review also revealed a high proportion of caesarean sections among maternal death cases, which prompted the introduction of relevant regulations.

Promoting evidence-based policies

70. In order to improve the quality of reproductive health services, the Government, in partnership with international organizations (UNICEF, UNFPA, USAID and WHO) has initiated the development, adaptation and institutionalization of national guidelines and protocols for clinical practice. During recent years the clinical practice guidelines and protocols have been adapted and introduced in almost all major areas of reproductive health and maternal and child health.

71. The findings of research, surveys (such as reproductive health surveys, the multiple indicator cluster survey and the reproductive age mortality study) and routine monitoring data are analysed and applied in evidence-based policy formulation. For instance, in response to the high proportion (30%-35%) of caesarean sections reported through monthly monitoring of the universal health coverage programme, a national clinical guideline and a protocol on that procedure was developed in 2013, with the support of UNFPA, USAID and the SUSTAIN project and professional associations. The Ministry, in partnership with WHO and UNFPA, is also responding to the rate of induced abortion, which remains high, through the development of an evidence-based protocol on induced abortion. According to the results of the survey on "Men and gender relations in Georgia" (conducted by UNFPA, UNDP, the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) and the Swedish International Development Cooperation Agency (Sida)) 9 per cent of sexually active women stated that they had undergone a sex-selective abortion. A comprehensive study is under way, with support from UNFPA, to reveal the actual prevalence and underlying factors of sex-selective abortion, which will inform the formulation of relevant policies and communication activities.

72. In addition the Ministry of Labour, Health and Social Affairs, in partnership with USAID, the SUSTAIN project and UNICEF, works on the regionalization of obstetric and neonatal care and the functional integration between the different levels of care that have been demonstrated to be of great importance to reinforce the effectiveness of maternal and child health interventions.

73. The effectiveness of maternal and child health interventions is also fostered by the promotion of quality improvement initiatives. USAID and the SUSTAIN programme, teamed with Joint Commission International, developed the Perinatal Care Accreditation programme, which aims to ensure a sustained drive by health-care facilities for improving the quality of perinatal care services and contributing to the reduction of maternal and infant morbidity and mortality.

74. Another good example of international support in providing evidence-based care for children is the Health-care Improvement Project in Georgia, supported by USAID and implemented by University Research Co., LLC. Pneumonia and other respiratory tract infections contribute to the highest morbidity among children under the age of 5 in Georgia. The project's baseline assessment identified many important quality gaps in the diagnosis and management of such infections in children at all levels of care, including in irrational and excessive antibiotic therapy, unjustified utilization of non-evidence-based medications, diagnostic tests and specialist services. For example, only 36.15 per cent of children hospitalized for pneumonia were treated with evidence-based first-line antibiotics. To improve the diagnosis and management of such infections among children, since 2012, the project supports participating ambulatories and hospitals of Imereti region by creating quality

improvement teams, providing intensive clinical and/or quality improvement trainings, and developing and distributing job-aids and other evidence-based tools on management of respiratory tract infections. Over 18 months, quality improvement interventions resulted in a 68 per cent ($p<0.001$) increase in justified antibiotic use, 33 per cent ($p<0.001$) increase in the use of first-choice antibiotics at hospitals and 71 per cent ($p<0.001$) improvement at ambulatories, compared to control facilities. These results show that the scaling up and institutionalization of proven quality improvement methods and/or tools countrywide most likely will lead to decreased antibiotic resistance, a lower death and disease burden among children, and cost-savings.

What are the remaining challenges and lessons learned?

75. While the progress documented in maternal and child health is impressive, the country needs further investments to attain Millennium Development Goal targets. Along with increased access to and uptake of services, the quality of care needs to be comprehensively addressed. Results from a study of the Health-Care Improvement Project in Georgia showed that quality improvement interventions could raise the standards of delivery of preventive, diagnostic and therapeutic services to maintain, restore or improve the health outcomes of patients. The integration of quality improvement into routine clinical practice should be taken into account. The regionalization of perinatal care facilities needs to be completed, a system of continuous medical education for maternal and child health-care personnel has to be implemented and further investments are needed in public awareness-raising activities.

76. More efforts and sustainable State investment are needed to maintain the progress achieved and make further steps towards achieving universal access to reproductive health services, including family planning, in order to reduce the total induced abortion rate and contribute to the reduction of maternal mortality and morbidity.

77. Furthermore, no comprehensive strategic planning exercise has been completed around maternal and child health programmes that would enable the formulation of a robust, results-based plan and harmonization and alignment of international aid, the lack of which might have underutilized the potential of existing governmental investment and technical and financial support from partners for even greater impact on maternal and child health outcomes.

Goal 6. HIV/AIDS, malaria and tuberculosis response

78. As noted in section II, Georgia has attained historic gains in HIV, tuberculosis and malaria response. The country has reached and sustained universal access to antiretroviral therapy since 2004, universal access to diagnosis and treatment of tuberculosis (including multi-drug-resistant and extensively drug-resistant strains of tuberculosis) and is moving forward to malaria-free certification.

What has worked?

79. Review of the progress in HIV, tuberculosis and malaria response, similar to that achieved in the maternal, neonatal and child health area, reveals that political commitment, resource investment (both domestic and international) and the engagement of international partners and civil society organizations in advocacy and

technical support has been critical. In addition all three disease components have been guided by comprehensive strategic planning exercises and coordinated resource mobilization that largely defined the success of the programmes.

Political commitment

80. Political commitment to successful HIV, tuberculosis and malaria responses has been declared in national development plans and health sector strategies since the late 1990s. The global and regional political platforms, including the Declaration of Commitment on HIV/AIDS adopted by the General Assembly at its twenty-sixth special session (resolution S-26/2), the WHO Stop TB Partnership and the Roll Back Malaria Partnership provided a robust overarching framework for action. The latest national health system performance assessment and the 2014-2020 strategic framework on universal health care and quality management for the protection of patients' rights both position addressing the three diseases among nine strategic priorities.

81. In addition to political commitment, since 2002 a national coordination body has been established to bring together major stakeholders and to guide the development of results-based national strategic plans for HIV, tuberculosis and malaria. A comprehensive planning exercise supported by the United Nations country team (UNICEF, UNFPA, WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS)) has made a critical contribution to strategic planning regarding HIV/AIDS. Support from UNICEF and WHO was also significant in programming concerning malaria and a similar exercise was conducted as regards tuberculosis with support from WHO, Médecins Sans Frontières and USAID.

Resource investments

82. HIV/AIDS prevention and control interventions are implemented through the HIV/AIDS prevention and treatment programme and the safe blood and antenatal care programmes, that include interventions for the prevention of mother-to-child transmission of HIV. The State programme on HIV/AIDS targets early detection of HIV through voluntary counselling and testing for such high-risk groups as patients with tuberculosis or sexually transmitted infections, prisoners, patients with hepatitis B and C, or patients with clinical signs of HIV/AIDS. The State programme on HIV/AIDS treatment covers outpatient and inpatient services, including antiretroviral therapy. The Government has substantially increased its allocation for opioid substitution therapy. Finally the safe blood programme envisages mandatory testing of all blood donors for HIV, hepatitis B and C and syphilis.

83. While the Government has increased its resource allocations for HIV response, from $39,718 in 2001 to $4,918,619 in 2013, the HIV/AIDS response in the country is still largely dependent on financial support from the Global Fund Fight AIDS, Tuberculosis and Malaria. The efforts in the area of HIV prevention, especially among youth, are largely supported by international organizations (UNFPA, UNICEF and USAID). Antiretroviral medications are provided solely through the support of the Global Fund. Overall the applications to the Global Fund on the basis of the national strategy, as well as support from USAID and the United Nations have been vital for the scaling up of evidence-based HIV prevention and treatment interventions in Georgia.

84. The country's progress in controlling tuberculosis has required a major investment from the Government and donors. The Government's contribution to the budget for addressing tuberculosis has doubled since 2008. The State's contribution, in an amount of GEL 10.5 million, comprised 65 per cent of the total budget for addressing tuberculosis in 2012. However, despite the expansion of State funding, a number of essential tuberculosis control functions (capacity-building, procurement and management of health-care products and equipment for diagnosis, anti-tuberculosis and second-line treatment medicines and their side effects, central and regional supervision of tuberculosis service points, and incentives and enablers for directly observed therapy) are largely or completely dependent on the Global Fund project. The Global Fund grant ends in 2016, as does the USAID tuberculosis prevention project, thus making 2013-2015 a critical window to determine which investments have brought the most value for money and how they can be sustained with domestic resources.

Investing in data quality for decision-making

85. The national tuberculosis programme, supported by the Global Fund tuberculosis project, established a supportive supervision system for local tuberculosis providers to monitor tuberculosis-related reporting and recording. The existing tuberculosis data management system allows the generation of quality data on all key indicators necessary for national and international reporting. The current initiative for developing an electronic tuberculosis data management system, supported by USAID, will significantly strengthen the tuberculosis surveillance system by allowing real-time and swift data exchange in order to facilitate programmatic and policy decision-making.

Promoting evidence-based care

86. International experts regard the Georgian model of HIV/AIDS treatment and care as the leading experience among countries of the former Union of Soviet Socialist Republics. The HIV/AIDS treatment and care programme is implemented by the Infectious Diseases, AIDS and Clinical Immunology Research Centre (National AIDS Centre), which, along with four affiliated regional facilities (Kutaisi, Batumi, Zugdidi and Sokhumi), provides free medical services through the State's HIV programme and the projects supported by the Global Fund.

87. Special attention is paid to adherence as an important determinant of treatment success. A programme to promote and maintain antiretroviral adherence has been developed that includes patient education, adherence monitoring and counselling. Since 2008, a home-based adherence support and monitoring programme started countrywide through the operation of mobile units.

88. Georgia is advancing towards eliminating vertical transmission of HIV by ensuring universal access to services for the prevention of mother-to-child transmission of HIV. Such services include HIV testing and prophylactic or therapeutic antiretroviral treatment for HIV-positive mothers and their newborns. Since 2005, there have been no cases of vertical transmission among babies born to HIV-positive women receiving antiretroviral treatment or prophylaxis.

89. Georgia has implemented new laboratory technology for the rapid detection of tuberculosis and drug resistance, allowing the country to identify 63 per cent of the estimated multi-drug-resistant tuberculosis cases notified in 2011.

What are the remaining challenges and lessons learned?

90. Low coverage as regards prevention and particularly HIV testing of key populations at risk leads to a high number of undiagnosed HIV cases or of cases diagnosed at a later stage. This has major implications for controlling the epidemic. Persons unaware of their HIV status continue to engage in high-risk behaviours, thus unknowingly transmitting the virus. Late diagnosis substantially increases the risk of mortality. Thus the expansion of prevention and harm reduction initiatives has been of critical importance.

91. The stigma and discrimination towards people living with HIV continues to be a major barrier to effective HIV prevention and service utilization. Negative social attitudes and low public awareness also remain as an obstacle. Beyond societal attitudes, State criminal laws, regulations and policies relevant to drug use and preventive work among injecting drug users and prisoners are among the limiting factors.

92. The laws on drug addiction prevention and control are not compatible with implementing effective interventions in public and penal sectors. Therefore, issue-focused and targeted advocacy efforts aimed at improving the legal environment are essential for the future success of HIV policy and response in Georgia.

93. The most recent analysis of the national tuberculosis response, in May 2012, identified delayed case detection, lack of a patient support system to ensure adherence and easy access to anti-tuberculosis drugs in pharmacies, which promotes self-treatment, as the main challenges. Ongoing fundamental health-care reforms have changed the context for tuberculosis control. In 2012, tuberculosis dispensaries were absorbed into private general medical facilities and tuberculosis control responsibilities were assigned to various public and private agencies with varying degrees of expertise and experience regarding tuberculosis.

94. A truly functional integration of tuberculosis services into the private network, if successful, should lead to improvements in the early detection of tuberculosis cases, referral and regularity of patient follow-up, and most importantly, in quality of treatment. At the same time, there are potential pitfalls that need to be addressed in order to achieve success, including reinforcing infection control measures and bringing the physical infrastructure for tuberculosis services up to internationally acceptable standards relating to space and air flow. The integration of tuberculosis services into the general health facility has some potential to decrease stigma related to tuberculosis. At the same time, stigma reduction must be balanced with appropriate information campaigns, in order to ensure that a paradoxical increase in stigma does not occur as an unintended consequence.

95. There is also need to understand drivers for stigma and to develop advocacy, communications and social mobilization materials that target stigma relating to tuberculosis in specific communities and population groups.

IV. Conclusions from the experience in implementing health-related Goals

96. While analysing Georgia's achievements to health-related Goals, a number of common facilitating factors become evident. The same catalysts have to be taken

into account in planning and supporting implementation of the development agenda beyond 2015.

Effective coordination of policies and programmes

97. Positive results and trends are documented in areas where national coordination councils or relevant inter-agency coordination mechanisms have worked. Such mechanisms have ensured coherent advocacy and successful advancement of the HIV/AIDS, tuberculosis and malaria agenda through a country coordinating mechanism. The Inter-Agency Coordination Council for Immunization is operational and has ensured a consensus platform among all key stakeholders on national vaccination programme policies and action. Progress has been also evident in maternal, newborn and child health since operationalization of the Maternal and Child Health Board. However, the experience of the Maternal and Child Health Board is relatively limited and needs further observation and analysis.

Robust national policies and plans

98. The robustness of national policy and programme planning has been critical in developing evidence-based and results-oriented strategies and effective alignment and harmonization of international aid in disease-specific programmes (e.g., national response for immunization, HIV, tuberculosis and malaria). However, with increasing global advocacy for an integrated universal health care agenda and strengthening platforms for health systems, the international community has to invest more in the provision of comprehensive guidance to low- and middle-income countries around national health strategic planning. The latter is critical both in the promotion of results- and evidence-based policies, effective allocation and use of limited domestic resources and harmonization and alignment of international aid to robust national policies and plans.

Civil society engagement

99. The engagement of civil society partners and representatives of affected constituencies, academia and the media has played a critical role in consensus-building and coordinated actions around HIV/AIDS, tuberculosis and reproductive health. The engagement of patients was also critical in the attainment of antiretroviral treatment gains and the latest initiative of Georgia in this regard concerns a 60 per cent reduction in the cost of treatment for hepatitis C.

International cooperation

100. International development assistance, including both financial and technical assistance, has ensured timely initiation of life-saving interventions in communicable diseases such as HIV, tuberculosis and vaccine-preventable diseases among children. Support from United Nations entities and specifically from UNFPA, together with USAID, has played a substantial role in strengthening national sexual and reproductive health response and generating data for decision-making through 3 rounds of reproductive health surveys. At present, Georgia largely relies on the support of the Global Fund for antiretroviral treatment and anti-tuberculosis drugs as well as harm-reduction interventions for the most-at-risk-groups. UNICEF, USAID, the GAVI Alliance and the Rostropovich-Vishnevskaya Foundation support has been invaluable in supporting the revitalization of

immunization programmes in the early years of transition and continuous expansion of the national immunization schedule with new and underused vaccines.

Government commitment to financial sustainability

101. The sustainability of donor-supported programmes is critical for maintaining the hard-won gains in public health outcomes. Governments need additional guidance and support for ensuring a successful transition in vaccine independence initiatives or phasing out from major global public-private partnership support for tackling HIV/AIDS, tuberculosis and malaria. The latter is especially critical for middle-income countries of Central and Eastern Europe and the Commonwealth of Independent States region that are scheduled to transition from the support of the GAVI Alliance and the Global Fund and are increasingly less eligible for international development aid.

Need for a broader global health vision beyond 2015

102. The global community, since the adoption of the General Assembly resolution 67/81 with its focus on universal health coverage, has agreed on the new global health vision for 2030. The vision has been recently reinforced by a high-level meeting hosted by the World Bank in partnership with the Secretariat of the United Nations and WHO. Therefore, universal health care has to be given greater prominence in the post-2015 development agenda, as the programme provides an essential platform for securing the human rights for the best attainable standard of health care as well as a platform for integrated strengthening efforts for health systems at the country level.

103. The post-2015 development agenda for Goals 6 and 8 has to target increased access to affordable and effective antiviral treatment for hepatitis C, as the disease has been accounting for a major disease burden, especially among middle-income countries. The newly emerging directly acting antiviral drugs represent an important source of hope for millions affected by hepatitis C and the global health partnerships building on the experience of the Global Fund and the International Drug Purchase Facility (UNITAID) have to target the establishment of a sustainable mechanism for ensuring affordable pricing of the relevant treatment.

104. Finally, non-communicable diseases, which account for the majority of adult morbidity and premature death in low- and middle-income countries (cardiovascular disease, cancer, related needs for the promotion of good health) must be placed at the heart of future human development. The Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS, adopted by the General Assembly in 2011 (resolution 65/277) and the Health 2020 agenda of WHO provide strong platforms on which to build. Through donor support and technical support (including from USAID and WHO) Georgia has made important gains to plan and implement interventions among the population and at the facility level to improve access to non-communicable disease prevention and control practices of high quality, though consistent technical support and international aid will be essential to scale up the best non-communicable disease practices countrywide.